

The Affordable Care Act (ACA) On Charitable Care In Kentucky What YOU Need to Know

Presented By

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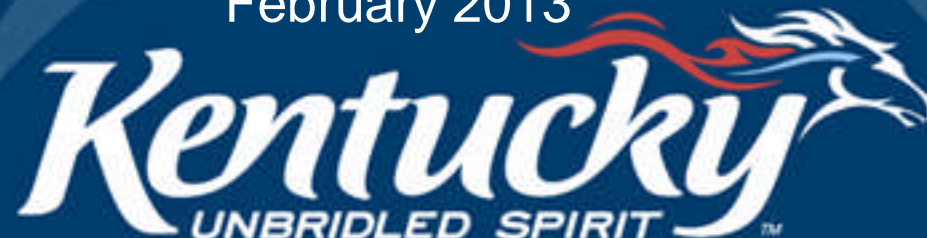
In Partnership With The:

Kentucky Free Health Clinic Association

Kentucky Academy for Family Physicians

Kentucky Rural Health Association

February 2013



Game Changer



2010

Patient Protection and Affordable Care Act

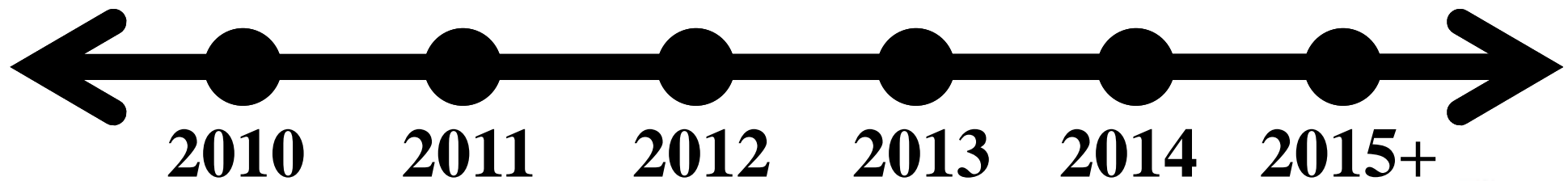
Barack Obama



Implementation

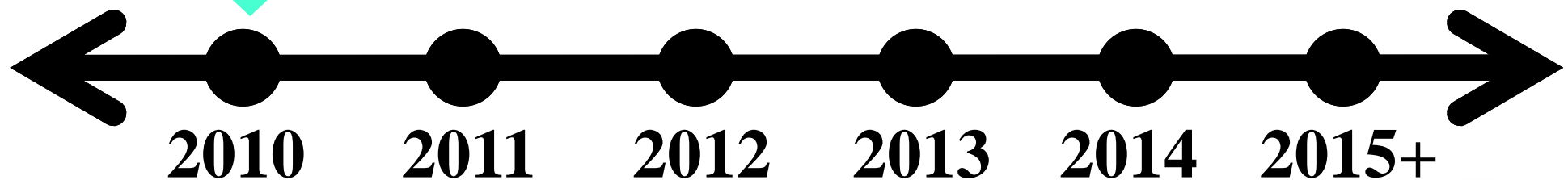
March 23, 2010

Patient
Protection and
Affordable Care
Act signed into
law



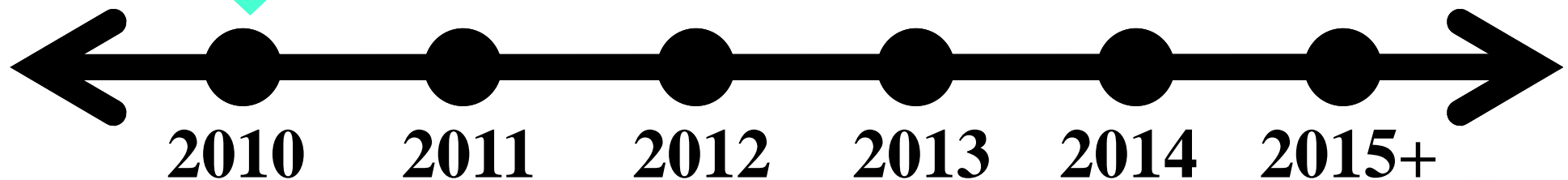
Implementation

- Prevention & Public Health Fund
- Federal Coordinated Health Care Office for dual eligibles
- Community Needs Assessment requirement for non-profit hospitals
- National Prevention, Health Promotion & Public Health Council
- Insurance plan for individuals with pre-existing conditions
- Coverage for young adults until age 26 via parent's plan
- No deductible or co-pay for certain preventive services
- Eliminating lifetime limits on coverage



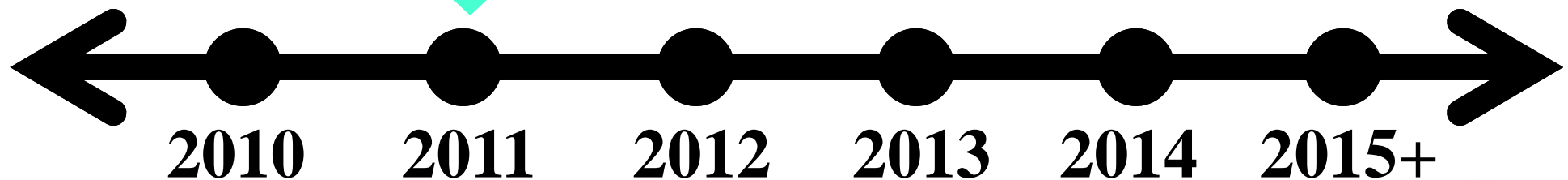
Implementation

- One-time \$250 “donut hole” rebate for seniors
- Financial help to sustain coverage for early retirees
- Small business tax credits
- Increased funding for FQHCs
- Health Care Workforce Commission
- No taxes on loan repayment and forgiveness programs for PCPs
- 10% tax on indoor tanning



Implementation

- Increased Medicare reimbursement rate for HPSA providers
- 50% discount for medications in “donut hole”
- Medicaid health homes
- Chronic disease prevention programs for Medicaid
- Free preventive care for seniors
- Require 80-85% of insurance premiums be spent on health care services
- “Money follows the person” demonstration grants
- National Quality Strategy
- Nutrition labeling at chain restaurants

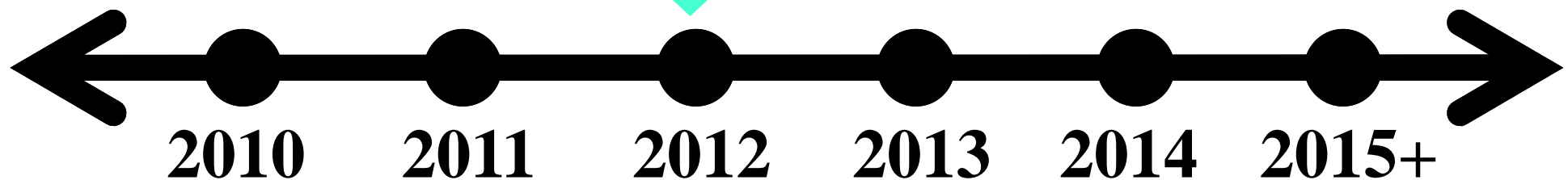


<http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm>



Implementation

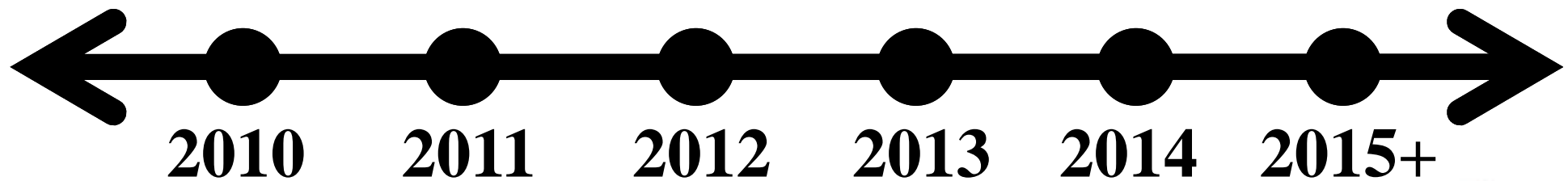
- Incentives for Accountable Care Organizations
- New racial, ethnic and language data reporting requirements
- Electronic health records
- Public reporting of hospital quality data
- Reduced Medicare payment for hospital readmissions



Implementation

June 28, 2012

ACA upheld;
Mandate is a tax;
Medicaid expansion
is optional for states



Yes, It's Still The Law



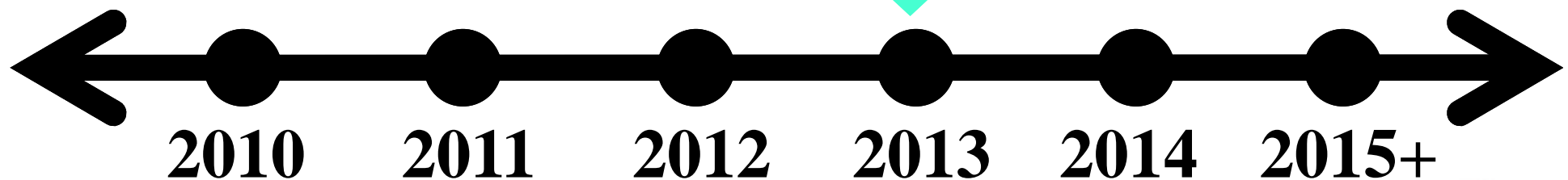
2012

National Federation of Independent Business et al.
v. Sebelius, Secretary of Health and Human Services, et al.



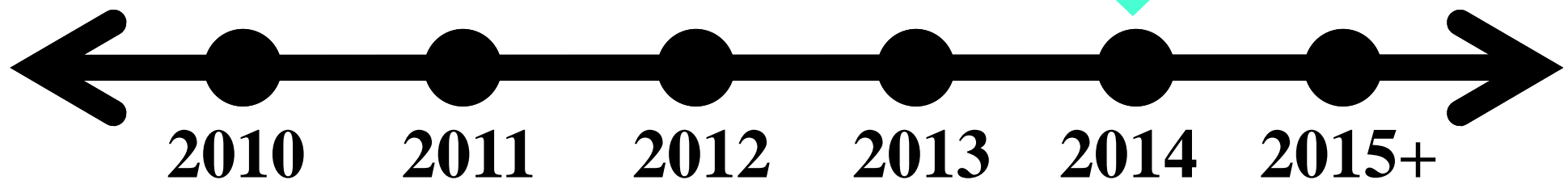
Implementation

- Funding for Medicaid programs with no-cost preventive care
- Increased Medicaid payments for PCPs
- Bundling payments per episode of care
- Two years of continued CHIP funding
- State notification re: Health Benefit Exchanges
- Reduced Medicaid and Medicare DSH payments to Hospitals



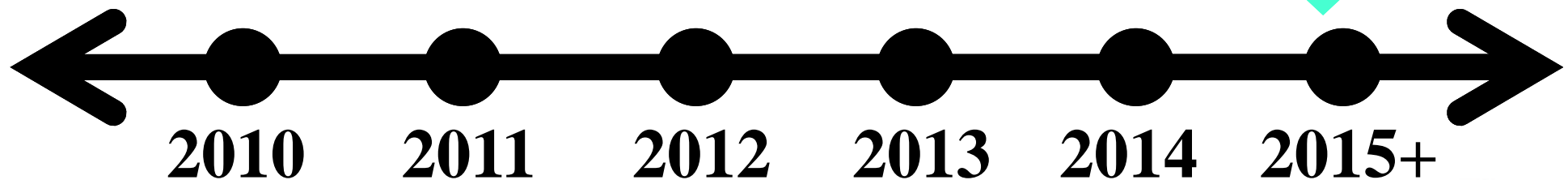
Implementation

- Establishing affordable insurance exchanges
- Individuals required to have health insurance or pay a tax
- Insurance subsidies available for 100-400% FPL
- States have option to expand Medicaid to 138% FPL
- Eliminate annual limits on coverage
- No exclusions for pre-existing conditions
- Small group plans must offer same rates regardless of gender or health status
- Increase small business tax credits



Implementation

- 2015: Link physician payment to quality of care
- 2016: States can form health care choice compacts
- 2018: Excise tax on high cost insurance
- 2020: Eliminates Medicare Donut Hole



Impact on Kentuckians

Most individuals will be required to purchase health insurance, starting in 2014. The new law prescribes that all health plans offered by the state-based insurance exchanges provide “essential health benefits” by 2014. To be determined through regulation by the Secretary of the U.S. Department of Health and Human Services, essential health benefits will include, at a minimum:

- ambulatory patient services;
- emergency services;
- hospital, maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services;
- chronic disease management; and
- pediatric services including oral and vision care.



Impact on Kentuckians

Most individuals will be required to purchase health insurance, starting in 2014.

Exclusions:

- Some limited religious exceptions (particularly Christian Science, and some Mennonite faiths).

Consequences:

- (1) Individuals who choose not to obtain coverage will be assessed a per-person tax penalty that is the greater of a flat sum or a percent of income. The tax penalties are phased in over time: \$95 or 1 percent of income in 2014; \$325 or 2 percent of income in 2015, and \$695 or 2.5 percent of income in 2016. In subsequent years the flat sum will be increased by a cost-of-living adjustment.

Impact on Kentuckians

(3) In addition to possible expansion of Medicaid, the law provides advanceable (subsidy) and refundable tax credits for premium assistance to people whose income is up to 400% of the federal poverty line (\$88,400 for a family of four). The actual amount of the premium tax credit depends on a person's income and the actuarial value of the second-lowest cost plan in the person's area.

Exceptions:

1. Tax credit is available only for those who have to PURCHASE coverage, and must be done through the Health Insurance Exchange.
2. Tax credit not applicable to those who have employer provided insurance.

Impact on Kentuckians

- The tax penalties are phased in over time: \$95 or 1 percent of income in 2014; \$325 or 2 percent of income in 2015, and \$695 or 2.5 percent of income in 2016. In subsequent years the flat sum will be increased by a cost-of-living adjustment.
- Certain individuals are exempt from the tax penalties.
 - A hardship exemption will be granted to people who would have to pay more than 8 percent of their income, net of the government subsidy, for the lowest cost plan in their area.
 - People who lack coverage for less than 3 months will not be subject to the penalty.



Impact on Kentuckians

- SHIFT to Preventative Care and Outcome Based Care
- Accountable Care Organizations (ACOs)

Accountable care models aim to address lack of care coordination and wide disparities in cost and quality of care in the U.S. health care system, perpetuated by the prevailing fee-for-service payment method, through shared incentives to manage utilization, improve quality, and curb cost growth.

– National Academy for State Health Policy (NASHP)

In other words, shifting high cost sick care to preventative care overall. Particular push for preventative care to reduce ER usage of primary care and hospital recidivism (return after being discharged). Which is why you are seeing hospitals purchase primary care offices throughout the state.



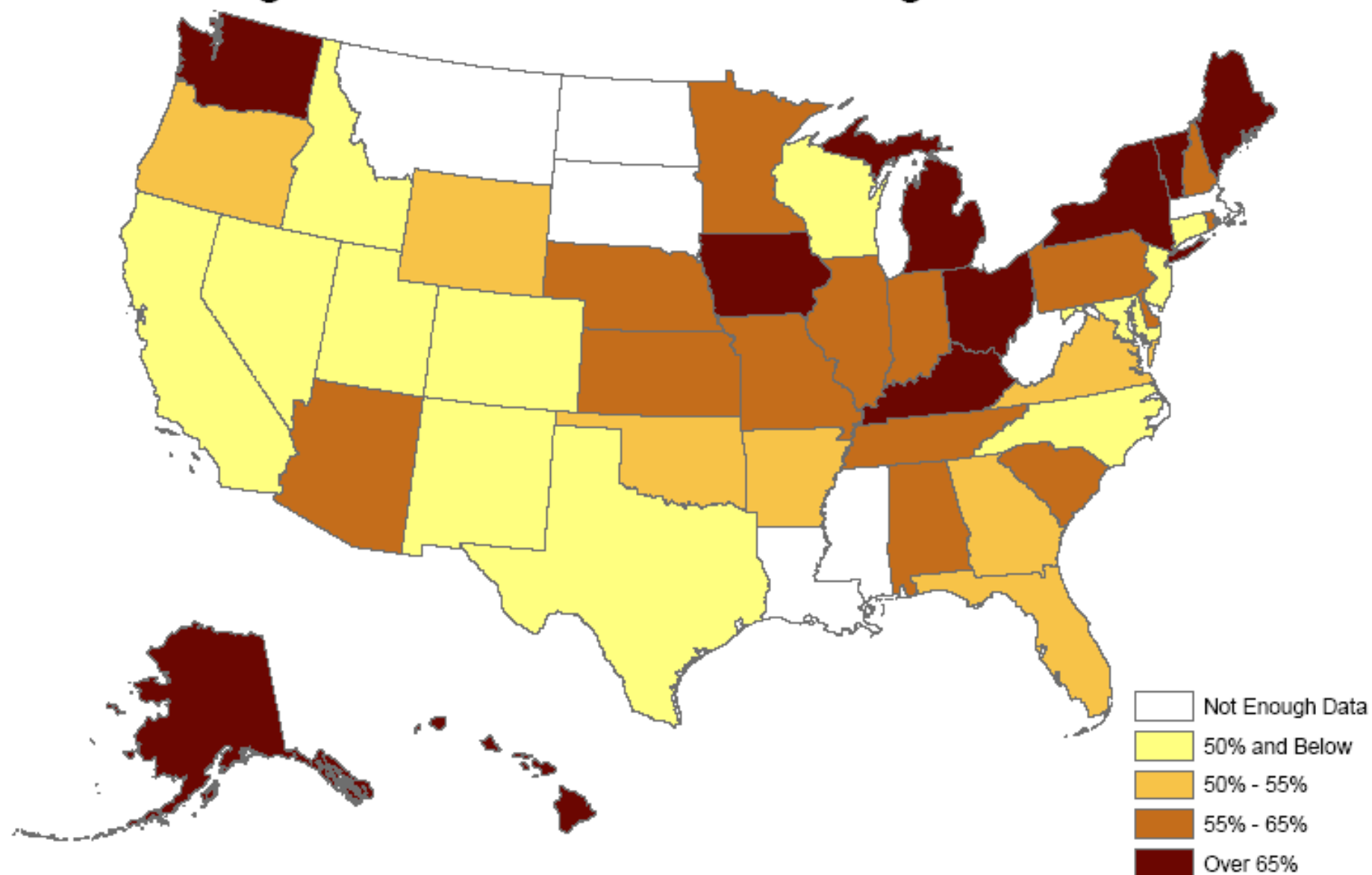
Insured/Uninsured in Kentucky

Health Insurance Coverage of the Total
Population, states (2010-2011),

	KY #	KY %	KY % of US Total
Employer	2,060,600	48%	1%
Individual	177,000	4%	1%
Medicaid	791,100	18%	2%
Medicare	584,300	14%	1%
Other Public	51,300	1%	1%
Uninsured	627,200	15%	1%
Total	4,291,400	100%	1%

Kaiser Foundation <http://www.statehealthfacts.org/>

Figure 4: Percent of Uninsured Adults
Eligible for Medicaid or Exchange Subsidies



Medicaid Expansion??

- Kentucky has yet to make a decision on Medicaid expansion.
- According to the Urban Institute, Kentucky's uninsured will be:
 - Approximately 6-8% (250,000–343,000) uninsured left **WITH** Medicaid Expansion.
Urban Institute, Timely Analysis of Immediate Health Policy Issues, January 2012.
 - Approximately 10%+ (429,000) **WITHOUT** Expansion
- Uninsured distribution primarily urban, and then sprinkled throughout state. Most likely to be undocumented.



Families USA Says...

Health Insurance Reform Is A Boon to Families and the Economy in Kentucky

- On average, each household in Kentucky will be \$1,968 better off in 2019 due to the provisions of the Affordable Care Act .
- Households with income of less than \$100,000 will receive the greatest financial benefit.
- Households with income under \$30,000 will be \$3,708 better off.
- Households with income between \$30,000 and \$50,000 will be \$1,639 better off.
- Households with income between \$50,000 and \$100,000 will be \$1,280 better off.

Consumer Growth

If you build it, they WILL come!

Insurance
Expansion

Prevention
Focused
Primary
Care
-Reduce
ER Care

Children's
Health/
Chronic
Disease
Care

Senior
Care
And
Women's
Health

Federal Process to Meet The Demand for the Underserved?

- Expand the federal safety net
 - \$11 billion into the Federally Qualified Health Centers (FQHCs) program, the new health reform law will dramatically increase the capacity of health centers.
 - Expansion of Rural Health Clinics (RHCs)



Kentucky's Health Centers

From the 2011 Roll Up for Kentucky FQHCs:

- 19 grantees with approximately 100 sites

- 278,242 patients served

- 1,047,526 visits

- 81.7% \leq 200%FPL (of known)

- 37.9% Uninsured

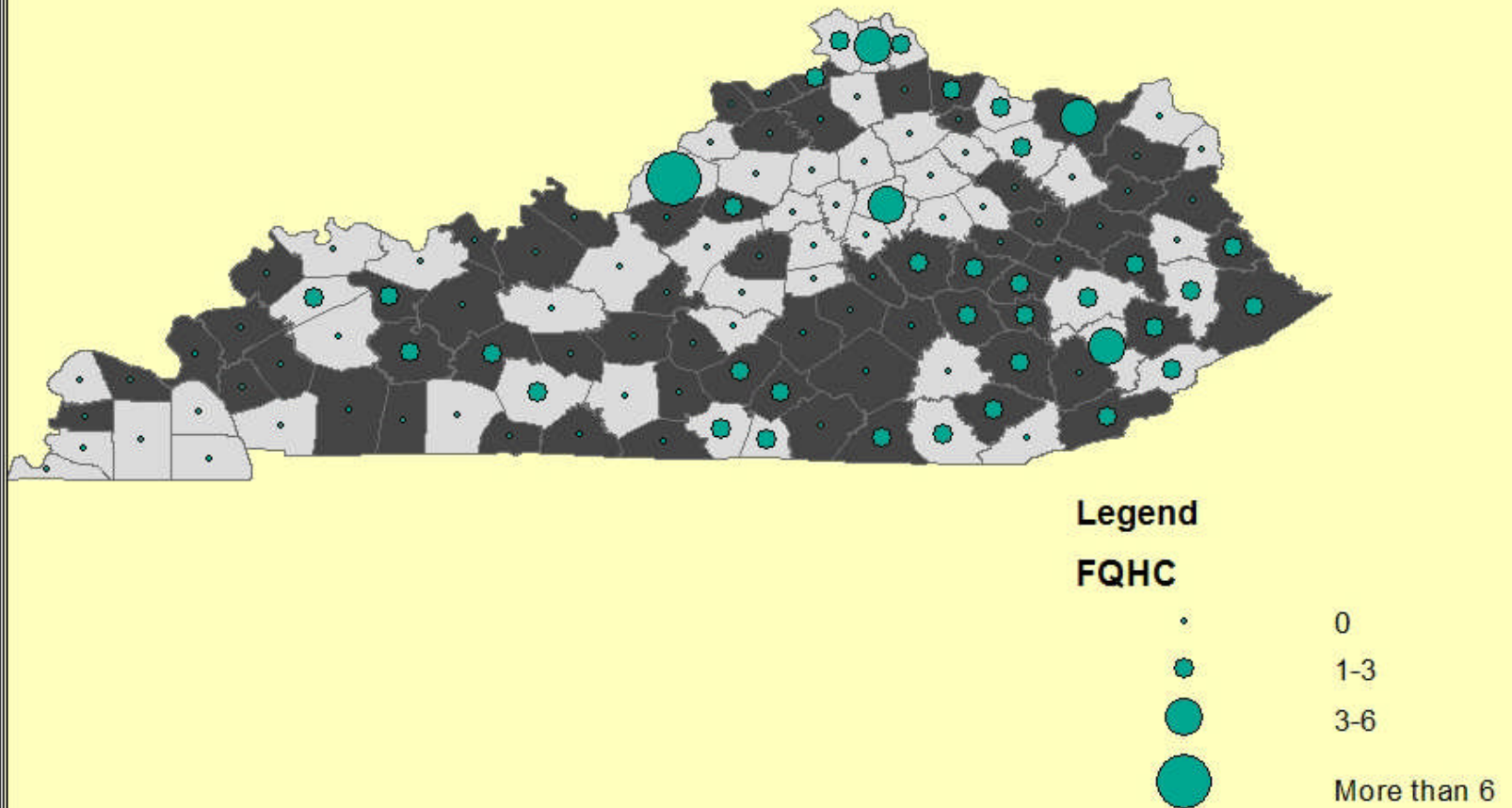
- 30.5% with Medicaid coverage

Health Centers provide care to 11% of Medicaid patients for only 1.6% of all Medicaid ambulatory care spending (NACHC Fact Sheet 2012)

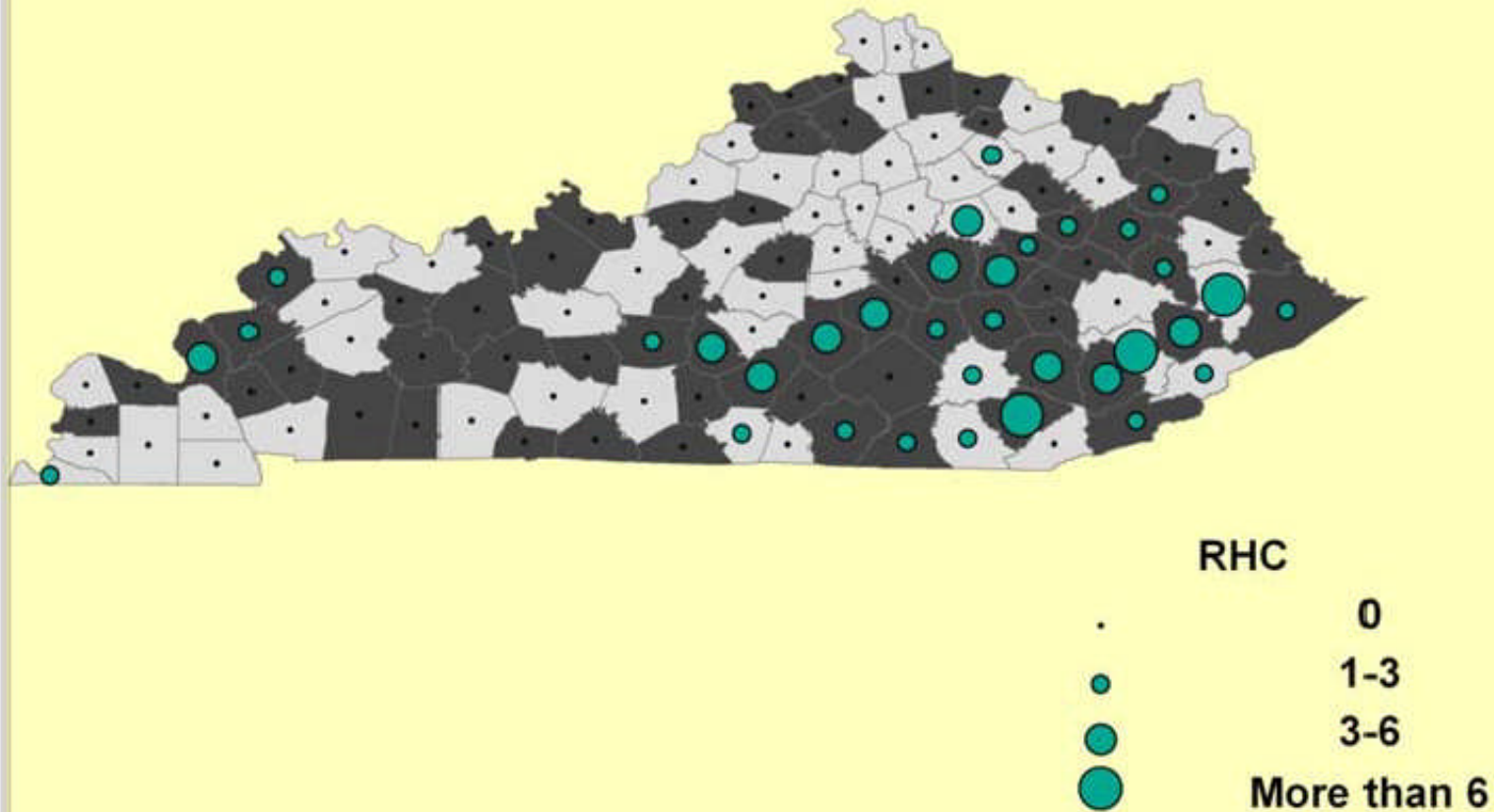
Approximately 172 current licensed Rural Health Clinics (RHCs)



Number of Federally Qualified Health Centers Per County

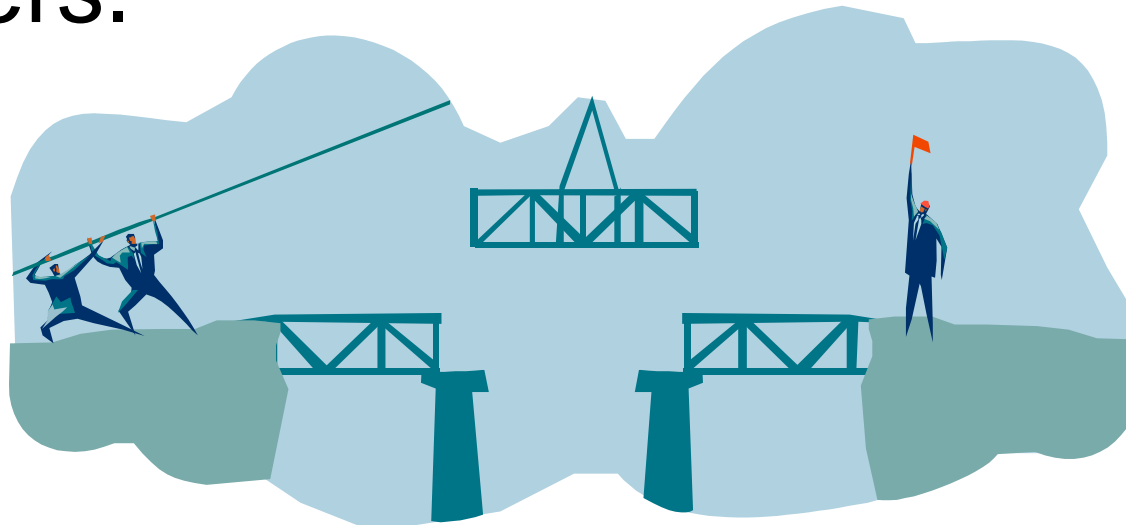


Number of Rural Health Clinics Per County



Problem...BIG GAP

- Big Gap between Increased Consumer Demand and Supply of Available Health Providers.



Kentucky Shortage Facts

Excluding Expansion

- **58.72** Primary Care (MD/DO) providers needed NOW in approximately 122 Shortage Areas in approximately 66 counties. **ACA = 117.44+**
- **30.23** Dentists needed in 30 Shortage Areas (DPSAs) in 26 counties. **ACA = 60.46+**
- **26.89** Mental Health (Psychiatrists) needed in 41 Shortage Areas in approximately 85 counties.
ACA = 53.78+

- Rehabilitation Sciences N/A (Physical Therapy, Disability services, etc). – Unknown

Data excludes facilities provider shortages (FQHCs, Prisons, etc.)



Kentucky Workforce Facts

Primary Care

- 2007 KIOM – Rural Health Workforce Report
Kentucky is likely to face a **shortage of primary care physicians of 25.6% by 2020**.
Rural areas are more likely to experience serious deficiencies than other areas.
- The HRSA Physician Supply Model (PSM) and a Physician Requirements Model (PRM) used by KIOM are based on certain assumptions:
 - There was an existing equilibrium between the supply of and demand for doctors in the base year (2000).
 - Growth in physician demand would be driven primarily by population growth and a growing number of elderly.
 - Assumed that patterns of health care use and delivery of care remain unchanged over the projection horizon (2005-2020) and that changing demographics are the primary driver of changes in physician requirements.
- Model omits OB/GYN.
- Jefferson County not included.
- ACA trumps analysis. Projected need by 2020 MUCH greater.



Kentucky Workforce Facts

Primary Care

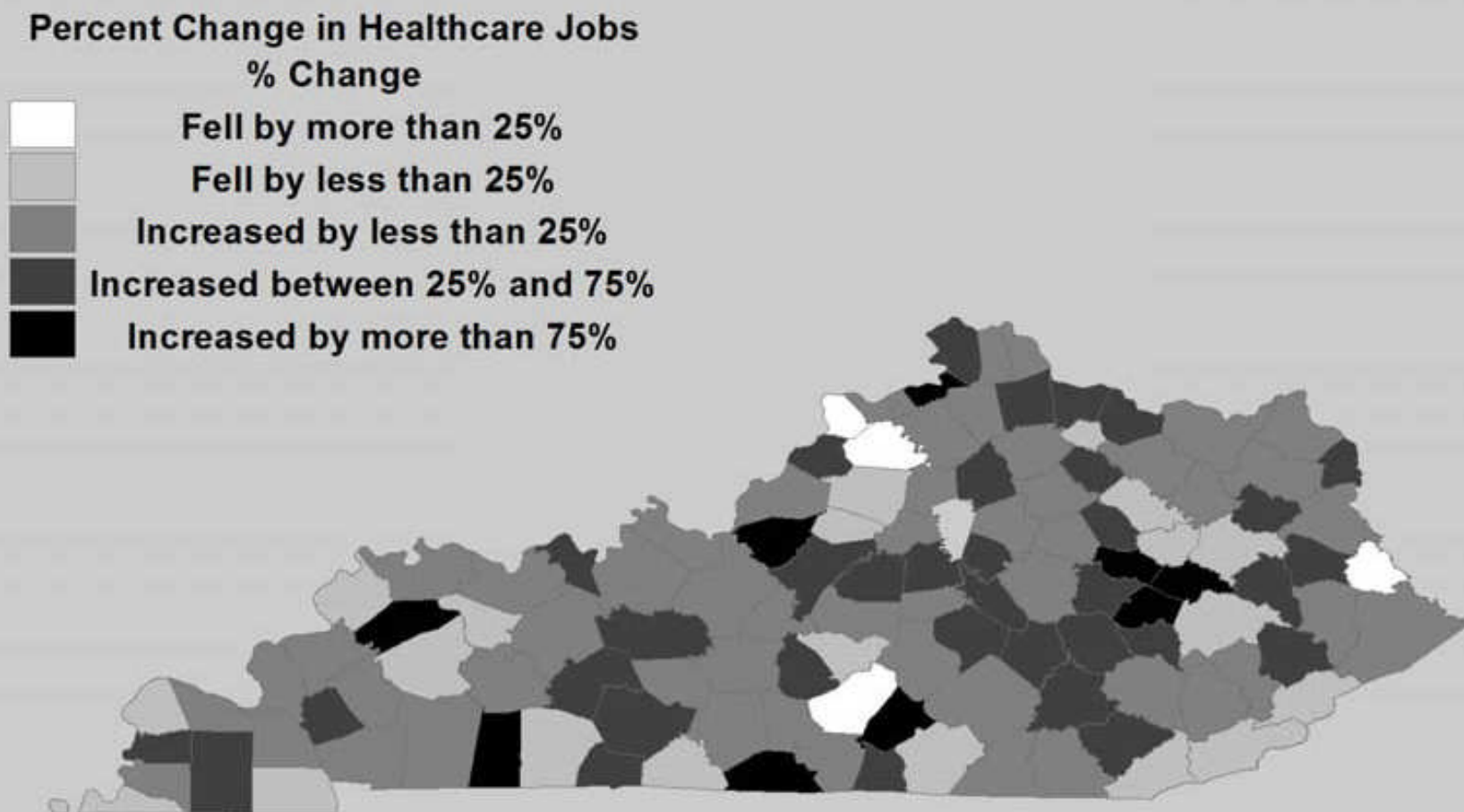
- December 2011; Jefferson County Primary Care Workforce Study, Louisville Primary Care Association (LPCA).

All Active Primary Care Physicians	2020 HRSA Requirement	2010 Supply	Additional needed to meet 2020 Requirement	Number Retiring*	Total needed to meet 2020 Requirement
Primary Care Physicians	794	697	97	239	336
General/Family Practice	318	218	100	90	190
Internal Medicine	341	319	22	101	123
Pediatricians	135	160	-25	48	23
OB/Gyn	111	109	2	48	50
TOTAL	905	806	99	287	386

- Same HRSA model used, so same assumptions.
- ACA trumps analysis. Projected need by 2020 MUCH greater.



Percentage Change in Healthcare Jobs, 2002-2011



Foundation for a Health Kentucky, 2012 KY Healthcare Market Report

Health Profession Pipeline FACTS

- Kentucky Medical Schools report 80%+ of their graduates are leaving the state and/or are specializing.
- Kentucky Dental Schools report that 80-85%+ of graduates are leaving the state.
- Those who stay are moving to METRO areas.
- APRN's and PA's were initially developed to increase access to primary care due to physician shortages. But APRN's and PA's are now specializing just as physicians did...and far faster than anticipated (HRSA).
- Nursing Programs reports they have closed or are considering closing MSN programs for now to require the PhD in Nursing.
- Significant retirements expected, but according to the association many of these retirees will leave the state.



So...What Does this Mean for Charitable Clinical Health Care Services?



Analysis of Charitable Care

“Reform will present significant changes for charity care programs and the uninsured they have served. As these changes occurs, charity programs will have much to consider about their evolving role in the greater health care system. They will fact the critical task of assessing and meeting the needs of the remaining uninsured, with implications for program delivery systems and business models, including the possibility of ceasing operations.”

-Center for Health Care Strategies, Inc. and AcademyHealth with funding from the Kaiser Permanente Institute for Health Policy



Supply of Providers

Current
Shortages

Educational
Challenges
And
Retention

Specialization

ACA
Expansion

Provider Workloads

If you build it, they WILL come!

Insurance
Expansion

Prevention
Focused
Primary
Care
-Reduce
ER Care

Children's
Health

Medicaid
to Adult
Men

Volunteer Hours



What Happened in Massachusetts

- Massachusetts Medical Society. 2009. Physician Workforce Study. 20 percent of patients reported difficulty obtaining care because the Provider not accepting patients.
- Among those with household income below 300 percent of poverty, the percentage of patients who reported difficulty obtaining care was nearly 30 percent.

Long, Sharon K. and Paul B. Masi. 2009. Access and affordability: An update on health reform in Massachusetts, fall 2008. Health Affairs. May: w578-w587.

Massachusetts Medical Society. 2009. Physician Workforce Study.



What Happened in Massachusetts

In light of the lessons learned after Massachusetts reformed its healthcare system and anticipated physician shortages, free clinics may want to re-examine screening criteria (FPL, income, health insurance status, and geographic location) and consider making their care available to people who are underinsured or those who experience difficulties finding a provider who is accepting patients to make sure they have not become outdated.

- Empowering Community Healthcare Outreach (ECHO)
 - National Faith Based Free Clinic Consulting Firm.
 - “Assessment of the Potential Impact of Health Reform on Free/Charitable Clinics”

Given that health reform extends Medicaid coverage to all people below 133/138 percent of poverty it may be necessary to raise the income threshold higher unless clinics want to target their services primarily to low-income undocumented immigrants and new immigrants for the first five years after U.S. entry, two groups that are barred from Medicaid.



Changes Coming In Kentucky

- Workforce Development and Regional Workforce Development Boards shifting from low wage emphasis to high wage Health Professions.
- Governor, General Assembly, etc., will begin initiatives around economic impact of health professions.
- Medicaid Expansion???
- Expansion of Federally Qualified Health Centers



Economic Impact of Providers

- UK College of Agriculture, Community & Economic Development Initiative of Kentucky (CEDIK)

2005 Rural Physician Report (republished 2012 Kentucky Health Care Market Report)

Average rural physician generates approximately \$1.7 million in revenue/community output, \$800,000 in payroll and creates 20 jobs in the physician clinic and the hospital.

2012 Rural Dentist Report

Average rural dentists generate approximately \$894,000 in revenue/community output and 11 jobs.



Change of Models, Thinking, and Billing

- Sick Model

TO

- Prevention/Early Intervention/Chronic Disease Maintenance Model



Change of Models, Thinking, and Billing

- Programs like the hospitals Disproportionate Share Program (DiSH) will no longer exist to assist the indigent as they will be insured.
- Billing drastically changing for providers, particularly hospitals. Outcome and Quality based billing.



Performance Based Models Tied to Billing

- Integration between Primary Care and Behavioral Health.
- Soon to include integration with Primary Care and Oral Health (NIOM Report - 2012)
- Promotion of the Patient Centered Medical Home (PCMH)
 - A PCMH is a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes. This includes the provision of preventive services; treatment of acute and chronic illness; and assistance with end-of-life issues. This care model promotes improved access and communication; care coordination and integration; and care quality and safety(American Academy of Physicians)



ACA and Performance Based Models

- The ACA includes the following provisions, among others:
 - establishment of a Center for Medicare and Medicaid Innovation that would pilot test broad payment and practice reform in primary care, including consideration of the Patient-Centered Medical Home,
 - a State Medicaid health (medical) home option,
 - the use of the medical home model for treatment or services under private health plans,
 - the requirement of health plans to provide incentives to promote and report on medical home services provided
 - the establishment of community health teams and a primary care extension program to educate and support primary care practices in the delivery of medical home services
 - establishment of a grant program to maintain and expand primary care units in teaching programs with priority to those who educate medical students on the Patient-Centered Medical Home.



ACA and Performance Based Models

- Accountable Care Organizations (ACOs) — referring to groups of providers that take responsibility for the care for an entire patient group — an official part of the Medicare program giving hospitals added incentive to scoop up physician partners.
- Congressional House Committee on Small Businesses
 - number of physicians who own their firms dropped from 57 percent in 2000 to 43 percent in 2009, according to Accenture data
 - New and established physicians in small or solo practices are increasingly joining larger practices or hospitals. Established small practices have reported difficulty in recruiting newly-licensed physicians. Some have speculated that the health care law will accelerate the trend.





THE BOTTOM LINE

The System Has Changed

- Sick Model to Prevention
- Workforce is significantly short, and will be for at least a generation.
- Due to workforce shortages, volunteer base likely to experience significant shortages.
- Federal and state expansion resources for underserved populations will be placed on expanding existing federal models/programs.
- Medical services now need to be thought of from an ECONOMIC impact to the community, state, and federally.



Considerations

1. Benefit Design

- FPL Increases?
- Focus on undocumented?
- Focus services on specialty care rather than primary care?
- Focus on Social Services components that complement health care received elsewhere (prescription assistance, health insurance navigator model, patient navigator system, etc.)?
- Partner with federal safety net?

2. Financing

- Consider that a shift of health system resources to insurance exchanges and Medicaid, and the lack of political or social appeal to care for the undocumented population may impact funding streams (donations, hospital support – DSH elimination, etc.)
- Due to primary uninsured to be undocumented, utilization may be different from current patients due to income levels, cultural norms, socioeconomic factors, etc.

3. Providers

- Newly insured likely lacked access to care for some time and have poorer health status and greater health needs. Implications for charitable care as they compete for providers time.

Considerations

Medscape Interview with Nicole D. Lamoureux, MA, Executive Director of the National Association of Free and Charitable Clinics (NAFC); Sept. 2012.

“Leaders of the free clinic movement were not invited to join the deliberations. That was not for a lack of trying. Thousands of letters were written to the White House, the House of Representatives, and the Senate.

My feet are tired from walking the halls of Congress, but we'll continue to do that because when we talk about our clinics, it is important to remember that these are our patients. They are not just numbers. We are not talking about 45 million faceless people out there; they are people.

We will continue to knock on the doors. We remain hopeful that both Congress and the President will include us in the future conversations that affect so many Americans whom we see on a daily basis. **As of yet, that has not happened.**”

<http://www.medscape.com/viewarticle/770688>



UNDER CONSTRUCTION – GROUND FLOOR



Alternative Models Support Charitable Care

- These alternative models can assist you in serving the newly insured low-patients you are already serving.
- Allow you to continue to have a large enough patient population to offset the cost of providing charitable services to the uninsured.
- And seek federal benefits (incentive payments, EMR incentives, loan repayment programs and J-1 Visa Waiver programs for recruitment of providers, etc.)



Regulatory and Reimbursement Framework for Kentucky's Safety Net Primary Care Clinics

	Primary Care Centers	Rural Health Clinics	Federally Qualified Health Centers
State licensure	√	√	
CMS certification		√	√
Shortage Area		MUA/P or HPSA	MUA/P
Profit Status	FP or NP	FP or NP	Nonprofit only
Hospital-based	May be	May be	Cannot be
Medicaid	All inclusive rate	All inclusive rate	All inclusive rate
Medicare	Fee for service	Mixed	Mixed
Private insurance	Fee for service	Fee for service	Fee for service
HRSA BPHC grants			√
Sliding Fee Scale for underinsured	No requirement	Only required for NHSC sites	Patients at or below 200% FPL at all sites

Some Benefits (for those in fed Shortage Areas)

Designation Requirements for Selected Federal Programs

Shortage Designation Option	National Health Service Corps	Federally Qualified Health Ctr Program	CMS* Medicare Incentive Payment	CMS* Rural Health Clinic Program	J-1 Visa Waiver
Primary Care HPSA	X		X	X	X
Dental Care HPSA	X				
Mental Health HPSA	X				X
Geographic HPSA	X		X	X	X
Population HPSA	X			X	X
Facility HPSA	X				X
Exceptional MUP		X			X
Medically Underserved Area		X		X	X
Medically Underserved Population		X			X
State Governor's Certified Shortage Area				X	

There is NO 1 Answer

- Each community's need is different, therefore no 1 charitable clinic's needs are the same.
- No one will require you to implement any model, rather we want you to understand the changing systems to understand how this will likely impact your organization and to begin preparations for any needed changes.
- To assist you in understanding and exploring all possibilities, Blue & Co. from Lexington, Kentucky has agreed to provide you our next webinar on these potential models to provide a better understanding on how they could work for you. And how these models can assist you accessing federal resources to continue to provide and expand your excellent services.



Questions



Add Your Voice – Become a Member

- Kentucky Free Health Clinic Association

- Annual budget \$25,000 or less = \$25.00
- Annual budget \$25,000-\$50,000 = \$50.00
- Annual budget \$50,000 or more = \$75.00
- No budget/clinic information = \$0.00
- Individual = \$50.00

Contact: Laura Ebert at lebert12@insightbb.com

<http://kyfreeclinics.org/>

- Kentucky Rural Health Association

- \$30 Individual Membership
- Discounted Bundle Memberships available for Agencies.

<http://www.kyrha.org/>



Next Webinar

This presentation

- February 6, 11am EST/10am Central

Blue & Co. – Alternative Models

- February 12, 11am EST/10am Central OR
 - February 13, 11am EST/10am Central
-

Social Work = 1.0 CEU

- Email chris.workman@ky.gov for CEU participation certificate.

